Gale Marana DDS
98-199 Kamehameha Highway Suite C-9 Aiea, HI 96701

Pearl Kai Dentistry
(808)488-7868

Patient Privacy, Disclosure, Consent and Office Policy Form

Name: _____

Notice of Privacy Practices:

Pearl Kai Dentistry exercises strict privacy practices in order to safeguard your personal information in accordance with Health Insurance Portability and Accountability Act of 1966 (HIPAA). You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. You may obtain a copy of our Notice of Privacy Practices, including any revisions at any time by contacting the staff.

Consent for Use and Disclosure of Health Information:

Purpose of Consent: By signing this form, you consent to Pearl Kai Dentistry's use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. You have the right to revoke this consent at any time by providing Pearl Kai Dentistry written notice of your revocation submitted to the Pearl Kai Dentistry Office Manager. Please understand that revocation will not affect any action we took in reliance of this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Photo Consent:

Purpose of Consent: The Staff at Pearl Kai Dentistry take photographs of your face and your pre/post-treatment smile for your insurance claims and purposes, for your treatment planning, for dental laboratory when needed to fabricate crowns, dentures and other restorations and for your own education in conjunction with treatment.

I consent to Use and Disclosure of Health Information, read and/or acknowledge receipt of Notice of Privacy Practices, and consent to take my photograph for office use only.

Signature: _____ **Date:** _____

If this Consent is completed by a personal representative on behalf of the patient, complete the following:

Parent/Guardian Name: _____

Relationship to Patient: _____

Signature: _____ **Date:** _____